VA 1.2:

Veterans Administration

PHASE V

of a comparative study of VA and private sector procurement, contracting and distribution of medical supplies and non-perishable subsistence

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Prepared by
Coopers & Lybrand

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CONTENTS

		Page
I.	STUDY BACKGROUND	
	A. INTRODUCTION	I- 1
	B. SYNOPSIS OF EACH STUDY PHASE	I- 2
	C. STUDY METHODOLOGY	I- 5
	D. KEY OBSERVATIONS	I- 9
II.	REVIEW OF RECOMMENDATIONS	
	A. COST-EFFECTIVE ALTERNATIVES TO THE VA DISTRIBUTION SYSTEM	II- 1
	B. ALTERNATIVES AND RECOMMENDATIONS PERTAINING TO VA PROCUREMENT PROCESSES	II-11
	C. SYSTEMWIDE MARKET ANALYSIS	II-24
	D. LOWEST COST METHOD OF SUPPLY	II-28
III.	LIST OF FINDINGS AND RECOMMENDATIONS	III-1

A. INTRODUCTION

The overall purpose of this study was to determine the effectiveness and efficiency of the Veterans Administration's (VA) current methods of acquiring and distributing medical supplies, pharmaceuticals, and non-perishable supply items. This involved accomplishing three broad study objectives:

- Determining and evaluating the cost efficiency of operating the VA depot wholesale distribution system. This included determining the costs of depot operations, supply inbound and outbound transportation, inventory handling and storage, and other associated factors.

- Evaluating the policies, procedures, and methods of the VA's acquisition process (procurement, storage, and distribution) for supply items, and comparing them with those of private sector hospital systems.

- Devising and recommending innovative and practical alternatives to the VA's current processes, to include identifying the lowest cost method of supply acquisition with supporting rationale.

This study was divided into five phases. In the first three, we collected, analyzed, and evaluated data pertaining to the VA and private sector. In the fourth phase, we presented and substantiated major recommendations to the current VA acquisition process.

The objective of this Phase V - Final Report is to summarize in one document the history of the study and the major findings and recommendations. When implemented, the recommendations will enable the VA to realize significant cost savings in the acquisition of medical and non-perishable supply items.

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B. SYNOPSIS OF EACH STUDY PHASE

Phase I

The objective of Phase I of this study was to document the VA procurement and distribution system. Coopers and Lybrand (C&L) researched and diagrammed each step in the VA acquisition cycle, including detailed functional work tasks and interorganizational coordinations.

C&L accomplished Phase I documentation for six different acquisition processes. They were:

- Depot Wholesale Distribution System
- Federal Supply Schedule (FSS) and VA Decentralized Contracts
- Routine Requisitions for Supplies/Services by VA Medical Center User Departments
- Emergency Requisitions for Supplies by VA Medical Center User Departments
- Medical Center Replenishment of Posted Stock
- Marketing Center Procurement of Major Equipment

Phase I was essential in producing a complete portrait of individual elements and functional work tasks in the VA's acquisition processes. This was beneficial in providing a total system view for both C&L's study analysts and the VA.

Phase II

The objectives of Phase II were: (1) to perform cost analyses of the VA depot distribution system, and (2) to identify private sector and VA acquisition policies, procedures, methods, and strategies. Phase II involved 14 discrete project tasks, for which C&L researched and completed extensive data analysis, particularly in two areas.

First, C&L researched current materials management in the VA and private sector systems, both at the corporate and hospital levels. Second, we performed extensive price analysis of supply items in three commodity groups (medical supplies, pharmaceuticals, and non-perishable subsistence). In doing so, we compared prices for items purchased from several sources, including the VA depots, FSS, Defense Logistics Agency, and commercial sources as reported by IMS America, Ltd., individual private sector hospital systems, the Red Book (for pharmaceuticals), and three national hospital regional buying groups.

Phase II was of major importance to the success of this study. C&L was able to demonstrate that, in general, the VA medical supply centers (VAMCs) receive "more favorable" prices for pharmaceutical, medical, and subsistence items (from the VA depot) than other hospitals in the U.S. "More favorable" meant that the purchase prices paid by VAMCs were less than the average comparative prices for identical items or items with the same salient characteristics of comparative quality, serving the same end use. This comparison proved to be extremely valuable throughout the study.

Phase II was also important in providing opportunities to visit both VA and selected private sector system hospitals, corporate headquarters, and the VA depots and Marketing Center. The interviews conducted and the data collected and analyzed materially contributed to findings and recommendations made in Phase IV.

Phase III

The objective of Phase III was to evaluate differences in the VA and private sector acquisition systems. We accomplished this by conducting in-depth research and evaluations of key elements in the procurement, transportation, and distribution processes. The 11 discrete tasks in this phase required collection of new data, as well as additional analysis and evaluation of VA and private sector processes.

Phase III was valuable in a number of ways. C&L identified and evaluated the effect that certain regulatory and statutory constraints have on VA government procurement, and how these differ from the private sector. We evaluated and compared factors that impact VA and private sector transportation procedures. C&L identified and evaluated differences in VA and private sector distribution systems. Finally, we developed indicators of efficiency and effectiveness for VA procurement and distribution procedures.

Phase IV

Phase IV was the culmination of all previous study work. The objective of this phase was to present major study findings and recommendations and to identify specific opportunities for future cost savings in the VA. This phase was divided into four major tasks, as follows:

- Compare the VA distribution system to those used by the private sector and determine if there are cost-effective alternatives.
- Recommend method(s) and strategy that should be used by the VA for evaluating the price differential between medical supplies purchased for VA depot distribution and those medical supplies purchased by the private sector.
- Develop alternatives and/or recommendations to the VA procurement processes that conform to regulatory constraints.
- Identify the lowest cost method of supply with supporting rationale.

In accomplishing the above tasks, the C&L study team drew extensively from both the information collected and evaluated in previous phases, and new statistical data required to support certain recommendations. The statistical data assembled in Phase II proved invaluable, particularly dollar values associated with depot operations and item analysis of medical supplies, pharmaceuticals, and non-perishable subsistence. Phase III analysis and assessment of procurement, transportation, and depot

distribution supported major recommendations. Newly assembled data included price and cost surveys from suppliers, cost estimates of different depot configurations, price analyses of items bought from other than VA depot sources, and updated (FY 85) costs of depot operations.

Phase IV resulted in major findings and recommendations which we believe, when implemented, will enable the VA to realize significant cost savings. The resulting data analysis also led us to conclude that the most effective and cost-efficient acquisition process is the existing three depot system.

C. STUDY METHODOLOGY

During this study, C&L analysts made over 200 trips to 13 states. We interviewed more than 325 people at various locations, including the VA Central Office, 3 private sector system corporate headquarters, 21 VA medical centers, 13 private sector hospitals, the VA Marketing Center, and the 3 VA depots. Interviewees included VA and private sector top-level policy makers, middle-level managers, and line staff. They included the Administrator of Veteran Affairs, the Associate Deputy Administrator for Logistics, directors of medical regions and departments, directors of procurement and supply operations, pharmacists, dietitians, commodity managers, contacting officers, depot inventory managers, and warehouse supervisors.

In the private sector, we researched the methods and strategies of materials management at three major hospital systems: Humana, Incorporated; Health Central Corporation; and Sisters of Mercy Health Care Corporation. Interviewees included corporate vice presidents, directors and managers of materials management, directors of purchasing, pharmacists, warehousemen, and transportation managers of commercial carriers. We also interviewed corporate officials of hospital supply firms to obtain data regarding commercial distribution processes that might contribute to evaluating the VA supply system.

The individuals we interviewed represented hospitals of varying sizes, geographic locations, and services. The private sector hospitals we visited ranged in size from 50 to 650 beds and were located in small and large metropolitan areas. These institutions provide a variety of services including acute and specialized care, clinics, and surgery. Some facilities were teaching hospitals associated with medical schools.

We collected data using interview guide questions geared specifically to each contract task. We conducted most interviews on site. If scheduling was a problem or traveling costs were too high, we conducted interviews by telephone. C&L staff, the VA Central Office, and appropriate private sector managers reviewed the data for accuracy and completeness.

On occasion, the need for special data required that we contact representatives of other government agencies, including the Defense Logistics Agency, the Office of Federal Procurement Policy, the Office of Management and Budget, the Federal Acquisition Institute, the General Services Administration, and the Interstate Commerce Commission.

We supplemented our interview findings with data from the 1983 American Society for Hospital Materials Management (ASHMM) National Survey of Hospital Materials Management. This survey was jointly produced by the ASHMM of the American Hospital Association and Coopers & Lybrand. The survey respondents included 500 hospitals from among 5,225 institutions accredited by the Joint Commission for the Accreditation of Hospitals (JCAH) representing all geographic areas of the U.S. The survey represented a statistical balance of hospitals in all bed-size categories. The results were analyzed by computer and the final output correlated with bed size, location, and type of service.

To determine the effectiveness of the VA supply system, we analyzed the total acquisition process by individual functions -- procurement, receiving, storage, and outbound transportation (distribution). Each function was reviewed and evaluated within the context of a systemwide perspective. Our findings were

compared and contrasted with functions and total system approaches used in the private sector, particularly in three large hospital systems: Humana, Inc.; Health Central Corporation (HCC); and Sisters of Mercy Health Care Corporation (SMHC). For each function, we analyzed organizational structures, operating procedures, written directives, workload, and quality of work results.

We identified and examined the policies, procedures, methods, and regulatory and statutory factors that influence the procurement of medical supplies, pharmaceuticals, and non-perishable supply items in the VA and private sectors. We determined the impact these factors have on item costs, and given the influence of such factors, we developed indicators of effectiveness and efficiency for the VA to better manage its procurement responsibilities and functions. We reviewed applicable portions of the Federal Acquisition Regulation (FAR) and Veterans Administration Acquisition Regulation (VAAR), and evaluated local procedures at the Marketing Center and individual medical centers. We discussed procurement policies and practices with authorities in such Federal Government agencies as the Office of Federal Procurement Policy, the Federal Acquisition Institute, and the Office of Management and Budget.

To accurately document VA and private sector materials management operations, we extracted and reviewed:

- Functional data, including samples of available historical records and materials management documents;
- Facility and equipment reviews, including area tours and review of floor plans; and
- Material and document flow data, including evaluation of key performance indicators and comparison of similar flows in other hospitals.

Current VA transportation procedures were evaluated for both inbound and outbound shipments. We reviewed carrier selection criteria, routing, delivery schedules, freight rates, government

regulations, and numerous transportation reports. We also reviewed transportation management at each depot, since each facility has a transportation section that handles all outbound shipments for its region. Each depot transportation chief was interviewed to obtain insights into current depot transportation procedures and to verify collected data.

In conducting inventory/distribution analysis, we reviewed the VA logistics system using detailed flowcharts to identify product and paper flows, decision points, and information flows in the system. The logistics process was documented from the identification of need through the delivery of supplies to the VA medical centers (VAMCs). We reviewed the logistics systems in the same private sector multihospital systems -- Humana, Inc. HCC, and SMHC -- also from need through delivery. We then compared the VA and private sector systems, focusing on the distribution and procurement elements.

We identified a number of differences between the VA and private sector systems, the most significant being the VA's use of a depot system for storage and distribution. We identified the key factors used in determining optimal inventory levels for the VA and the private sector hospitals. We reviewed the methodologies used to calculate inventory levels and examined the factors that affect the ability of both the VA and the private sector to achieve optimal inventory levels.

Finally, we based our development of cost on data specific to the depot operations. We used depot distribution operating costs for the fiscal year ended September 30, 1985, as the source for our baseline costs. The primary sources for depot cost data were the Quarterly Supply Depot Functional Cost Accounting Report (VA Form 10-2952) and the Supply Fund Cost Accounting and Budgetary Report (RCS No. 10-242). This information was verified by the depot directors and fiscal services at the Central Office.

D. KEY OBSERVATIONS

Some important observations underlie this report. First, the Veterans Administration's mission and function set it apart from the private sector; therefore, to some degree, it is influenced by a separate set of conditions. Second, the private sector hospital system, and the individual hospitals within those systems, are not consistent in managing purchasing and supply functions.

As a Federal Government organization, the VA operates in an environment that is more closely scrutinized than any organization in the private sector. The VA's budget and spending habits are reviewed and critiqued by individuals outside the VA and outside the medical community. Its procurement activities must comply with the Federal Acquisition Regulation (FAR) and the VA Acquisition Regulation (VAAR). The government procurement and acquisition process requires competition, provides for socio-economic considerations, and requires a clear audit trail for the expenditure of public funds. This process is often more procedurally cumbersome, time-consuming, and administratively costly than private sector systems. Also, the VA must procure from mandated sources such as the Federal Prison Industries and the National Industries for the Blind and Other Severely Handicapped; at the same time it must support such government-sponsored and assisted programs as small business, minority-owned, and women-owned businesses.

In the other hospital systems we reviewed, we saw that individual hospitals within those systems do not all function and operate under the same policies or procedures in materials management. They have different business philosophies and approaches to dealing with changes in legislation and industry procedures that affect hospital costs. Corporate-level material managers also operate under different constraints than their counterparts in the VA. Unlike the VA, they do not have to respond, on a regular basis, to the public (through the Congress or special interest lobby groups) while still performing their primary functions. Rather, thay are able to focus on internal organizational matters.

II. REVIEW OF RECOMMENDATIONS

A. COST-EFFECTIVE ALTERNATIVES TO THE VA DISTRIBUTION SYSTEM

INTRODUCTION

We identified and analyzed five major alternative distribution systems to determine feasibility and cost effectiveness. A detailed workplan was developed to identify potential savings and calculate the major cost elements for each alternative.

We categorized the alternatives into those requiring the total elimination of the VA depot system and those that modify the existing depot configuration. Some of the alternatives were taken directly from private sector hospital system practices; others were innovative approaches with no comparable applications.

Two alternatives required closure of the VA depot distribution system. One of these considered replacing the depots with a system in which the VA Marketing Center would award national contracts to vendors with direct delivery to the VAMCs. A second alternative would require the VAMCs to purchase supplies from the Defense Logistics Agency (DLA) instead of ordering from the VA depots.

The other three alternatives considered some kind of modification to the existing depot configuration, without totally eliminating the VA depots. These included the feasibility of expanding the depot system by adding a new depot facility, the feasibility of consolidating the depot system by closing one or more of the current VA depots, and the application of the break bulk concept for the VA distribution system.

A discussion of our analysis, considerations, and findings or recommendations related to each alternative follows.

1. National Contracts for Direct Vendor Delivery

A major issue addressed during the entire project was whether the entire VA depot distribution system should be eliminated and replaced by some alternative supply system. One such alternative would be a system providing for direct delivery of supplies from the vendors to the VAMCs and OGAs under national contracts. This distribution method is commonly referred to as direct vendor delivery (DVD). This method was recommended by the President's Private Sector Survey on Cost Control (Grace Commission), to be followed by a time-phased closure of the VA depot distribution system.

Our methodology was designed to capture the contractual (product) price plus delivery (transportation) cost of items purchased in a decentralized distribution system. For this method to be cost effective, the savings realized from VA depot closures would have to exceed any anticipated increase in vendor delivered unit price.

Our methodology reflected several assumptions that were both viable and necessary for comparative purposes.

(1) Non-perishable subsistence supplies would be obtained locally.

(2) VAMCs would enjoy the same level of customer service currently provided; and

(3) Items obtained from mandatory sources (National Institute for the Blind, National Institute for the Severely Handicapped, and Federal Prison Industries) were not to be considered in this analysis, since many of these organizations are not capable of providing direct delivery.

We determined that the benefits of retaining the VA depot system outweighed the advantages of other alternatives. The benefits of using the depot distribution system include:

- Lower unit supply costs to the end-users as a result of the volume purchases made by the supply depot system;

- De facto standardization of the VA supply items;
- Predictable (monthly) schedule of VA medical center workload for receiving depot deliveries; and
- Consistent service and prices for all VAMCs regardless of size or geographic location.

Implementing a DVD distribution process, which would totally eliminate the VA depot system, would result in a first year cost increase to the VA of more than $25 million.

Finding: **The VA should not replace the depot distribution system with an alternative system providing for direct vendor delivery.**

2. Defense Logistics Agency (DLA) Assumption of VA Wholesale Depot Operations

The feasibility of the DLA assuming the procurement and distribution of medical items and non-perishable subsistence for the VA is a logical alternative. DLA procures, stocks, and distributes medical supplies, pharmaceuticals, and subsistence for 168 major military hospitals, more than 900 military medical/dental clinics, and more than 40 nonmilitary OGAs.

DLA already procures many medical items used by the VA. The two organizations participate in the VA/DOD Shared Procurement Program. Under this program, the VA and DLA divide contracting responsibilities based on several criteria, including (1) primary procurement groups, (2) workload and dollar value, and (3) primary items used in respective hospitals. DLA is the primary source for a significant percentage of the perishable subsistence bought by VA medical centers.

We determined the feasibility of DLA assuming the procurement and distribution functions for the VA in three steps: 1) we made a feasibility inquiry to DLA; 2) we performed an item price analysis; and 3) we performed a systemwide cost analysis.

DLA conducted a brief and informal analysis, stating that it appeared that the agency could be considered as an alternative

within the objectives of this study. DLA also specified that a detailed study would be required to consider all aspects and alternatives, including operating policies and philosophies to ensure that each organization could continue to perform its mission.

We performed a price analysis of specific items, comparing FY 85 and FY 84 VA vs. DLA end-item prices. As a test group, we compared prices of VA depot items in each commodity group. Our analysis showed that buying 148 selected items from DLA would have resulted in a single year cost increase to the VA of more than $15 million.

Finally, we performed a total system cost analysis based on the estimated annual supply costs to all VAMCs had the VA depot items been procured from DLA. We computed the difference between the VA depot markup and the DLA depot markup, the DLA surcharge, and the potential savings realized from closing the VA depots. The resulting systemwide costs incurred by the VA to purchase from DLA totaled an additional $25.75 million.

Finding: **DLA assumption of the procurement and distribution functions for the VA is not a cost-effective alternative at this time.**

3. Additional Depot Facilities

One might assume that increasing the number of facilities in a distribution system would reduce transportation costs, improve customer service, increase inventory investment, and increase logistics costs. With shorter distances between depots and customers, overall transportation costs decrease and service and response time improve. Improved customer service may result in increased customer sales. However, as more depots are added to a system, anticipated savings and apparent opportunities for improvement may be outweighed by increased inventory costs and overall system distribution costs. Trade-offs between increased costs and the potential benefits of system expansion must be examined to determine the cost effectiveness of adding facilities

to a current system. It may prove that the additional costs are warranted.

We compared the cost of expanding the current VA system to FY 85 total logistics costs. Our methodology involved identifying the cost associated with each expansion site and developing total system costs. Because we were comparing an existing system to a proposed system, we made a series of assumptions to allow a comparison between current and projected costs at a given point in time.

Several assumptions were necessary in this analysis. These were: (1) current VA depot locations are appropriate; (2) VAMC customer service levels would remain constant or improve; (3) the VA's major transportation mode would continue to be by motor carrier; (4) projected sales would reflect cumulative FY 85 figures (no sales growth is projected); (5) expansion would be limited to only one site reflecting the trend in distribution to decrease, not increase, the number of distribution facilities in a system; (6) any expansion facilities would be leased rather than owned; and (7) commodity mix of depot stock would reflect FY 85 product mix.

To accomplish the comparative aspect of this task, we selected potential sites; reviewed leasing facilities vs. owning; developed current depot and customer profiles; estimated both current and projected transportation costs; reassigned VAMCs to proposed sites; determined fixed and variable costs associated with each depot operation in the proposed and current system; and calculated total system costs for expansion.

Our analysis showed that for every proposed expansion site, total system logistics costs would increase and customer service or other benefits would improve only marginally.

Finding: **The VA should not add a depot to its present distribution system.**

4. Consolidation of Existing Facilities

We evaluated the alternative of consolidating the three depots currently in the VA system in terms of transportation costs and incremental operating expenses, and compared these revised system costs against FY 85 system costs.

We expected the costs of transporting goods to the customers to rise. Likewise, we expected a corresponding rise in direct operating expenses at the remaining distribution facilities. We also anticipated that these increases would be offset by a decrease in overall system costs as a result of eliminating facilities.

It does appear that overall system costs would be reduced by consolidation, but whether or not this is really feasible is another issue. Could the remaining facilities handle the anticipated increase in workload without restricting future sales growth or creating an excessive expenditure of capital? It would be difficult to identify realistic potential savings unless this issue is addressed.

Our methodology attempted to identify potential savings through consolidation and evaluate its feasibility as well. Our methodology was based on testing scenarios that reduce the number of depots from three to two and from three to one. We analyzed two-depot consolidations for Hines/Somerville, Hines/Bell, and Bell/Somerville. The centralized depot scenario was conducted for Hines. Several factors influenced our selection of Hines for the single facility analysis:

- Hines is centrally located. If its location were coastal, transportation lead-times to another coast would likely prove to be prohibitive.
- Total transportation costs would most likely be lower from a central location than they would be from an East or West Coast location.
- The Hines facility is physically best suited to handle the consolidated shipping volumes.

Our analysis was based on several assumptions: (1) current VA depot locations are appropriate; (2) VAMC customer service levels would remain constant; (3) the major mode of transportation would continue to be by motor carrier; (4) the projected sales figures represent a realignment of actual FY 85 sales (no future sales growth is projected); (5) the VA depots are not currently operating at maximum capacity; and (6) commodity mix of depot stock would reflect the current product mix.

We developed depot and customer profiles for each possible consolidation; estimated both current and projected transportation costs; reassigned VAMCs to remaining depots; identified fixed and variable costs associated with each depot operation in the proposed and current systems; calculated total system costs; reviewed facility capabilities; and calculated costs, if any, associated with maximizing current storage space.

Our analysis indicated that the VA could achieve operational savings from each consolidation considered. However, there were several other factors to consider beyond operational cost savings, including storage capacity of existing depots, required capital expenditures to increase this capacity, future growth, and the warehouse storage space that would be required for the VA to realize savings through standardization. When combined, these latter considerations led us to conclude that this alternative was not operationally feasible.

Finding: **Although potential system savings exist through consolidation (whether reduction to two or one), no alternative is operationally feasible with current facilities. The current three depot system should remain.**

5. Conversion of Depots to Break Bulk Facilities

The break bulk concept is a variation of the "just-in-time" inventory strategy, developed and implemented in Japan, but rarely practiced in the United States. This alternative repre-

sented a unique approach for the VA since there is no comparable use in the private sector. Because of the difficulty in accurately projecting cost impacts, much of our analysis was theoretical.

Just-in-time inventory management requires a dramatic change in the vendor-buyer relationship. The time allowed to identify need, communicate replenishment order, and deliver supplies is drastically reduced.

We analyzed this alternative by calculating the incremental costs identified with the break bulk system and comparing these costs to the projected savings. The projected savings were calculated by estimating the reduction in depot inventories that would occur if depot safety stocks were eliminated. Potential savings were then stated in terms of time value of inventory.

We developed a mathematical model to estimate the impact of the break bulk concept on VAMC inventories. This model was tested with several supply items that are not obtained from the VA depots. We generalized these findings to the combined VAMC inventories.

We based our analysis on the following assumptions: (1) operating expenses associated with the current VA depot system would not change in the break bulk scenario; (2) service levels to the VAMCs would remain at present levels; (3) the LOG I system in its present configuration is not capable of supporting the break bulk concept.

In a break bulk environment in the VA, supplies would continue to pass through the current depot facilities. The VA Marketing Center would continue to perform the contractual function. The LOG I system would consolidate VAMC orders and transmit them to the appropriate vendors. Vendors would continue to ship products to the three current depot locations.

Once vendor shipments were received at the depot locations, the supplies would be separated and allocated to specific VAMC destinations. Products would be moved directly from the receiv-

ing area to the shipping area, where a staging zone would be designated for each VAMC. All accumulated products would be shipped to each VAMC once a month.

We would anticipate a reduction in inventory holding costs since supplies would pass directly from the receiving dock to the shipping area. Incremental expenses would occur as a result of increased inventories at the VAMC level, including increased administrative costs to manage in-bound transportation, increased cost of purchasing, and the added cost to upgrade the LOG I system to support the break bulk application and the cost to remove the shelving from the depots.

If the VA depots were to be converted to break bulk facilities, products would flow directly from the receiving area to the shipping area to be staged for shipment. This would eliminate safety stocks in the depot; but, as our calculations indicated, it would necessitate increased stock levels in the VAMCs and extensive lead-time in ordering.

Other factors would also be critical. In-bound transportation would require intensive management; the Marketing Center would have to negotiate added vendor lead-time. Each of these would require increased administrative time and expense, plus the probable addition of more personnel.

It would also be necessary to modify the LOG I system in order to support a break bulk application. This modification would primarily affect the replenishment cycle. It would be necessary for the system to consolidate replenishment orders from each VAMC by vendor. The vendors would receive instructions for shipping consolidated quantities to each of the three depot locations. The system would also have to provide the depot facilities with a breakdown, by VAMC location, for each of the consolidated vendor orders.

Finally, it would be necessary to reconfigure the layout of each of the VA depots. The storage shelving would have to be removed to allow supplies to flow from receiving directly to the staging/shipping area.

Finding: **Under certain conditions, it would appear the break bulk scenario might result in some net savings for the VA. However, projected increases in VAMC station inventories would be nearly the same or greater than the inventory reductions realized at the VA depot level. Consequently, it does not appear practical to implement such a system.**

B. ALTERNATIVES AND RECOMMENDATIONS PERTAINING TO VA PROCUREMENT PROCESSES

INTRODUCTION

We evaluated a number of alternative procurement methods, affecting both Marketing Center and medical center responsibility. We also presented a price evaluation methodology to monitor item prices on a continuing basis.

Our recommendations fall into two major categories: those that would affect procurement processes at the VA Marketing Center and those that would affect procurement activities at the medical centers. They were made with the full understanding that the VA operates in a procurement environment that is significantly more constrained than that of the private sector. The VA budget and expenditures are open to public review and critique. Its procurement activities and processes must comply with statutory and regulatory provisions as directed by the Federal Acquisition Regulation (FAR) and the VA Acquisition Regulation (VAAR). We were also mindful that the Federal Government procurement process requires competition, provides for socio-economic considerations, and requires a clear audit trail for the expenditure of public funds.

Our recommendations consist of both long-term and short-term initiatives. When implemented they should enable the VA to benefit from short-term initiatives, while planning long-term actions in greater detail.

ALTERNATIVES TO MARKETING CENTER PROCUREMENT PROCESSES

1. Multiyear Contracting

We believe the VA Marketing Center (VAMKC) could realize significant cost savings by employing multiyear contracting on a selected basis. Multiyear contracts include the requirement for more than one year's acquisition of supplies or services. Although contract quantities are planned at a specific level, the program is budgeted and funded annually.

We reviewed the VAMKC's present contracting procedures and methods. We discussed the advantages and methods of multiyear implementation with procurement personnel at the VA Central Office and Marketing Center. We analyzed provisions of FAR Part 17, Special Contracting Methods, and the Report of the Committee on Governmental Affairs, United States Senate, to accompany S.2300, entitled Civilian Agency Multiyear Contracting Act of 1984. We discussed the subject with acquisition managers/directors of large private sector systems, to obtain their recommendations. We also talked to one large vendor of medical supplies/pharmaceuticals to obtain a supplier's viewpoint. Finally, we analyzed the VA's expenditure patterns to determine the primary sources from which the medical centers obtain their supplies and the amount of funds spent.

There are several advantages to using multiyear contracting. First, multiyear contracting encourages manufacturers and vendors/distributors to reduce prices. The offeror can plan VA quantity requirements over a 2- or 3-year period, thus making more definite commitments when ordering supplies and planning stock inventories. Second, multiyear contracting protects the VA against increased prices in succeeding years. Third, since multiyear requirements are procured once for a 2- or 3-year period, procurement administrative costs are significantly reduced. A fourth advantage is that multiyear contracts can enhance depot stock deliveries and reduce nonavailability.

The VA Marketing Center's contract funding structure is compatible with the FAR for multiyear contracting. These contracts are financed by a unique, self-sustaining revolving fund, known as the Supply Fund. These are considered "no-year" funds and are commensurate with provisions of the Anti-Deficiency Act.

Proposed Marketing Center multiyear procurement would be compatible with FAR Part 17. The benefits of multiyear contracting are amplified by the Civilian Agency Multiyear Contracting of 1984. This Act is intended to amend the Federal

Property and Administrative Services Act of 1949. It extends multiyear contracting authority government-wide in an effort to improve federal procurement effectiveness and efficiency. The proposed Act of 1984 would authorize civilian procuring agencies to enter into multiyear contracts (not to exceed 5 years) when such contracts are determined to be in the government's best interest.

Our research also produced documented support of multiyear contracting by the General Accounting Office and the Office of Federal Procurement Policy.

Recommendation: **The VA Marketing Center should employ multiyear contracting on a selected basis. The length of these contracts (whether 2 or more years) should be left to VAMC management discretion, based on their expertise, current negotiations, and the Marketing Center's prior experience in purchasing respective items.**

2. National Contracts Program for Nonstocked Pharmaceuticals

The Marketing Center (VAMKC) has developed an effective and cost-efficient National Contracts Program for acquiring pharmaceuticals not stocked by the depots at less than Federal Supply Schedule (FSS) and local procurement prices. This program is not meant to replace the current depot system, but rather supplement it. Its intent is to consolidate individual hospital requirements now bought from nondepot sources and realize discount prices through quantity procurement. This is accomplished by taking one nondepot item at a time, analyzing hospital purchasing habits, and then obtaining firm commitments to order requirements from specific vendors who have been issued competitive awards. We see this National Contracts Program as an excellent bridge between local/FSS purchase and the depot system.

The VA saved $5.2 million through the National Contracts Program during FY 85. The program consisted of implementing national contracts for 17 intravenous (IV) solutions and 7 line items of ethical drugs, with more than 95 percent of medical

centers participating. The market distribution was divided among three vendors.

Prior to implementing this program, VAMCs bought these products through the Federal Supply Schedule or local procurement. The VAMKC devised the program plan, received approval from the VA Central Office and Executive Committee for Therapeutic Agents (ECTA), and then solicited participation by VAMCs.

The Marketing Center believes that the National Contracts Program can be expanded to include many more nondepot pharmaceuticals. One such item is insulin. If as few as 60 percent of the VAMCs commit to purchasing all their insulin through national contracts, the Marketing Center estimates the VA could save $3.5 million annually. This figure could exceed $5 million with 100 percent VAMC participation. Diagnostic reagents are another class of items believed worthy of evaluation for this program.

During FY 85, VAMCs expended $158.4 million for pharmaceuticals from FSS and $75.4 million from local procurement sources. These purchases are generally at prices much higher than those offered by the depot and would be worthy of VA review as possible candidates for the National Contracts Program.

Implementing a National Contracts Program on a major scale would be a sound business decision. Backed by a requirements base of 172 medical centers, the VA represents one of the largest buying systems in the U.S. Discount item prices for volume purchasing is a fact of the marketplace. However, when VAMCs purchase nondepot items on an individual basis, they lose the buying power of a large organization.

The VA Marketing Center has devised a draft program plan for expanding the National Contracts Program which it believes will bring about extensive savings. This plan is based upon the VA's willingness to accept the therapeutic equivalency ratings established by the Food and Drug Administration (FDA) and agree that the agency can use an item from any qualified manufacturer.

Recommendation: **The VA should expand the number of pharmaceutical items procured through the National Contracts Program for nondepot stocked items. Current VA experience indicates that under such an expanded program, millions of dollars in potential savings are probable.**

3. Federal Supply Schedule Contracts

Federal Supply Schedule (FSS) contracts are the VA medical centers' primary supply source, based on expenditures for medical supplies and pharmaceuticals. The combined expenditure for these commodities was $327 million in FY 84 and $350 million in FY 85, representing 42 percent of total VAMC expenditures for medical supplies and pharmaceuticals.

The FSS program provides federal organizations with an established structure and process for acquiring supplies and services from commercial sources. The Marketing Center administers the program in the VA and awards competitive contracts with commercial firms at stated prices. These indefinite delivery contracts are the basis of schedules the VAMCs use to place delivery orders directly with suppliers.

Single-award schedules are made with one contractor, to provide one or more items (based on competitive solicitations). Each schedule lists supplies/services provided and the price. Multiple-award schedules are placed with suppliers for their line of products based on competitive, negotiated contracts. These schedules list items by supplier first, and then by product available from each source.

In analyzing FSS, we reviewed provisions of the Federal Acquisition Regulation that describe the general structure of the program and acquisition procedures (Part 8, Required Sources of Supplies and Services, and Part 38, Federal Supply Schedule Contracting). We conducted interviews with procurement and supply personnel at VA Central Office, Marketing Center, and several VAMCs. This gave us information pertaining to VA acquisition policies, procedures, and methods pertaining to FSS.

We reviewed and analyzed VA data reports which list items the VAMCs purchased from the VA depots and prices paid, and FSS prices paid by VAMCs for the same or medically equivalent items. We also compared FY 84 prices paid for VA depot medical supplies and pharmaceuticals for the same or comparable items available through FSS.

We believe that there are significant shortcomings in the current FSS program. It is cumbersome to use and unwieldy to administer. The extensive use of multiple-award schedules can actually be detrimental to the government. Finally, FSS prices do not consistently provide item cost savings. We concentrated our analysis on the latter two issues.

Multiple-award schedules list many suppliers offering a large number of comparable items. Whereas single-award schedules encourage acquisition by the "line item" required, multiple-award schedules promote a "shopping list" approach. This can actually increase government costs, when computed in the aggregate.

Not all items should be on single-award schedules; multiple-award schedules would be the preferred choice for some items, such as orthopedic implants and surgical instruments because of differences in quality. Yet, a major portion of VA medical supplies -- adhesive tape, gauze, cottonballs, bandages, adult diapers, canes, and other non-critical items -- are ideal for single-award schedules and could lead to cost savings.

Single-award schedules are not always suitable for pharmaceuticals. The very nature of this commodity -- with the continuous introduction of new drugs, the high degree of regulation, and the lengthy and complex administrative process required to establish single-award schedules for drugs -- would suggest another method of acquisition. We believe that the National Contracts Program, described earlier in this section, represents a feasible, cost-saving alternative to purchasing pharmaceuticals.

When evaluating purchase prices, our analysis showed that FSS does not consistently provide the lowest overall cost alternatives. This is inconsistent with procurement/contracting law and regulations which are designed to enable the government to purchase supplies and services at the lowest costs to meet its needs. Therefore, FSS is often not the best source from which to purchase.

For example, we conducted an item price analysis of pharmaceuticals, comparing FSS prices with IMS America, Ltd.'s 10th decile (average of the most economical purchases) invoiced prices. Our analysis showed that for 132 out of 207 occurrences (64%), the private sector (source of IMS' data base) had lower prices than the VA did through FSS. A separate item price analysis of medical supplies, based on a C&L national survey, showed that the private sector paid lower prices than available through FSS in 27 percent of the occurrences tested (19 out of 71).

We conducted another item price analysis, comparing prices of VA depot items with FSS prices for the same items. For 215 comparable pharmaceutical items tested, the VA depot price was lower for 203 items (94%). Of the 71 comparable medical supply items, all VA depot prices were lower. If VAMCs had purchased all their requirements for these 286 items from FSS sources rather than the depot, the VA would have paid an additional $54.4 million for these items.

Recommendations: (1) The Marketing Center should identify a candidate number of FSC 6510 non-life-threatening items and convert these from FSS multiple-award to single-award schedules.

(2) The VA Marketing Center should reduce its dependency on multiple-award schedules for pharmaceuticals and increase its use of the National Contracts Program for this commodity.

4. The VA/DOD Shared Procurement Program

This program consists of the VA Marketing Center and Defense Logistics Agency (DLA) joint purchase of common medical supplies and pharmaceutical items. This program also provides medical requirements for the Public Health Service (PHS). The objectives of the program are to eliminate duplicate procurements by the VA and DLA, to prevent duplicate items from entering into service, and to provide joint contractual documents for procurement.

The VA Marketing Center and DLA award indefinite quantity requirement type contracts to manufacturers or vendors. Each activity then writes orders to stock respective depots as part of its agency's wholesale distribution system. The current procurement program consists of more than 384 contracts, covering 1,894 line items, at a contractual value of $413 million.

Some of the more significant benefits of this program include:

- Reported VA and DOD combined savings of $12.8 million in FY 84 and $17.5 million in FY 85.
- A means of obtaining economical prices through consolidated requirements and large volume discounts.
- An outstanding process for evaluating and introducing new items into the joint procurement program.

Recommendation: **The VA and DLA should continue to expand their efforts to identify new medical supply and pharmaceutical items to bring into the program, particularly items that are now bought primarily from local procurement sources, since these items are normally associated with the highest prices.**

ALTERNATIVES TO VA MEDICAL CENTER PROCUREMENT AND CONTRACTING PROCESSES

1. Local Procurement

The VA medical centers typically procure 38 percent of medical supplies and 17 percent of pharmaceuticals from local procurement sources. In contrast, the private sector systems we reviewed obtain less than 15 percent of their medical supplies and less than 10 percent of their pharmaceuticals from local sources. For the VA, this amounts to 28 percent of all VA medical supplies and pharmaceuticals purchased via local procurement sources. The 2-year total from these sources equals $453 million.

In the VA, local procurement of medical items generally means purchasing from open market commercial sources, without the benefits of any prearranged or negotiated agreement with vendors or distributors. VAMCs typically enter the open market as one-time, nonpreferred customers.

In collecting data, we obtained information regarding local procurement and contracting policies, procedures, and methods. We analyzed VAMC expenditures on the basis of single transactions and accumulated annual totals. Our analysis showed that the prices VAMCs pay through local procurement are generally 25 to 50 percent higher than VA depot price. Our research reflected, in general, the same results at each VAMC for both FY 84 and FY 85.

Local procurements represent the second highest expenditure sources for medical supplies and pharmaceuticals. However, when the cost of general items and subsistence are included, local procurement becomes the highest expenditure source among VAMCs. The combined VA FY 84 and 85 local procurement expenditures for medical supplies, pharmaceuticals, general items, and subsistence totaled $868 million.

Our interviews and data indicate that each medical center functions autonomously. Hospital officials and medical staff determine products of their own choice (FDA/VA approved). The

preferred product is often purchased from local procurement, generally at higher prices than medically equivalent depot items at lower prices.

There is no effort among VAMCs to consolidate medical requirements within the same geographical area. This results in more single purchase orders and a correspondingly higher total cost. In addition, few VAMCs we visited attempt to establish any contractual agreement or other competitive arrangement with local distributors for annual local procurements of medical items These items are purchased repetitively, often in small quantities, at higher market prices and administrative cost for the VA.

Unposted items -- those not normally stocked in the hospital inventory -- pose several significant problems. First, the VA lacks inventory control records and therefore cannot audit what was bought, the quantity, who received the items, and their final use or disposition. The lack of control and accountability leaves the VA vulnerable to fraud, waste, and abuse. Second, this same lack of control and coordination leads to duplicate procurements of the same items, at uneconomical prices. Third, the VA Central Office lacks the management control to determine when a VAMC is deviating from FAR or VAAR policy and procedures.

The unposted expenditures for local procurement are very significant. In both FY 84 and FY 85, more than 81 percent of all local procurements for medical supplies and pharmaceuticals were unposted. For the 2 years, more than $370 million of the $453 million spent for medical supplies and pharmaceuticals via local procurement can not be traced or analyzed.

Currently in the private sector, there are major efforts to control procurement costs at the hospital level. One of the primary methods is through standardization (which we will discuss at greater length later in this report). For the VA, standardization represents the long-term solution to reducing the numbers and expenditures for local procurement.

As a short-term solution to reducing local procurement expenditures, the VAMCs should solicit and award annual indefinite quantity requirements contracts with local vendors/distributors, employing formal FAR/VAAR solicitation and award procedures. All available large and small business concerns in the area should be solicited, including disadvantaged and women-owned firms. More than one award should be made to firms in the competitive range.

VAMCs should also consolidate requirements and purchase as a buying group, using the indefinite quantity requirement contracts, where two or more VAMCs are located in the same city or in close geographical proximity. Each of these hospitals normally act independently when purchasing medical supplies and pharmaceuticals in the local area. About 65 to 75 percent of VAMC medical supplies and pharmaceuticals are common. Consolidated purchasing of these items on a city/area basis could significantly reduce VAMC expenditures on local procurement.

These initiatives can be implemented in less than 1 year. If properly employed and managed, they can effectively reduce both the number of local procurement actions and the associated expenditures until a VA-wide standardization program is realized.

Recommendations: (1) Each VAMC should solicit and award annual indefinite quantity requirements contracts with local vendors/distributors.

(2) Where two or more VAMCs are located in the same city or in close proximity, they should consolidate requirements and purchase as a buying group, using indefinite quantity requirement contracts.

2. Federal Supply Schedule (FSS) Purchases

In an earlier discussion of the Marketing Center and the FSS program, we showed that (1) FSS prices are not always lower than other commercial sources; therefore, FSS is not always the most advantageous source for the Federal Government; and (2) single-

award schedules are more beneficial to the government for some medical supplies, because they encourage "line item" rather than brand name acquisition.

In addition to the above shortcomings, FSS sources are not always responsive to VAMC needs. FSS suppliers sometimes refuse to ship items unless the orders meet a certain minimum dollar threshold. This often results in VAMCs seeking local procurement at higher prices.

We believe the VA should take positive actions to reverse these shortcomings and work toward reducing its dependence on FSS. However, this should be a long-term goal, commensurate with the realized success of other long-term goals, namely standardization and the increased use of the National Contracts Program. Some positive VA action is necessary in the interim, since FSS is the greatest source of VAMC expenditures for medical supplies and pharmaceuticals.

Recommendation: **The VAMCs should reduce their dependence on FSS by employing preaward indefinite quantity requirement contracts in each VAMC local area, and by increasing their use of the National Contracts Program.**

3. Amendment of VAAR 808.001

We have discussed the need for VAMCs to solicit and award indefinite quantity requirement contracts as a means of obtaining significantly lower item prices for local procurements. VAAR 808.001 contains a list of mandatory sources of supply, in order of preference, from which VAMCs must procure their requirements. Under current provisions, local procurement sources are the last priority. Consequently, VAAR 808.001 must be modified to enable VAMCs to procure items at the lowest prices, when available through a local indefinite quantity requirement contract.

The current order of preference in VAAR 808.001 should be amended to include the new language, indicated by bold lettering for the two listings shown below.

- VA excess;
- VA supply depots;
- Other government agencies' excess;
- Federal Prison Industries;
- National Industries for the Blind & Other Severely Handicapped;
- General Services Administration and Defense Logistics Agency depot systems;
- Decentralized contracts (VA contracts originated by the Marketing Center);
- **Local procurement sources, when the purchase is based on indefinite quantity requirement contracts, and the total cost of a particular transaction is less than that through Federal Supply Schedule contracts.**
- Mandatory Federal Supply Schedule contracts;
- Optional Federal Supply Schedule contracts; and
- Local procurement -- commercial concerns, educational or nonprofit institutions **(other than through an indefinite quantity requirement contract).**

Recommendation: Amend VAAR 808.001 as stipulated above.

4. Purchasing Responsibilities Within the VA Medical Centers

Some VAMCs use technicians or other personnel to purchase user department medical items. This circumvents the established supply acquisition system.

The supply services organization in each VAMC is established as a centralized acquisition activity. The primary purpose of a centralized activity is to consolidate the technical expertise and efforts of acquisition personnel. This leads to more technically effective and cost-efficient acquisition.

Conversely, independent purchasing by user departments is normally more costly. These purchases are relatively small quantities, normally at open market retail prices. This kind of purchasing perpetuates inadequate planning practices and leads to more local procurement. Even when emergency procurement is needed, supply service contract specialists are more qualified to acquire the items from available sources of supply.

Recommendation: All purchasing responsibilities within the VAMCs should be centralized in the supply services organization.

C. SYSTEMWIDE MARKET ANALYSIS

An essential element of cost-efficient supply acquisition is the method and strategy used to evaluate the price differential between supplies purchased for VA depot distribution and supplies purchased by the private sector. The VA Marketing Center is responsible for conducting market research and analysis before awarding depot supply contracts. Contracting officers rely on a number of factors to assess the reasonableness of prices, including the previous contract price, Federal Supply Schedule prices, and published price information sources (e.g., Redbook & IMS drug reports for pharmaceuticals; Manufacturers List Price Bulletins for medical supplies; and distributor (Hollebs) retail price lists for subsistence). Before an award can be made, the VA contracting officer must verify that the proposed unit price is at least 15 percent lower than the "best available price" from any other source.

This strategy for analyzing prices is flawed in a number of ways. Last year's award price does not always reflect current market conditions. Since FSS pricing is based on single unit purchase, a comparison to FSS ignores the benefit of volume discounts. Finally, published prices too often reflect general retail prices paid by individual hospitals and not the purchases made by large multihospital systems, which often obtain discount prices through large quantity purchases.

The market research accomplished at the Marketing Center should reflect the important role the VA plays in the hospital supply marketplace. It should enable the VA to improve its position in contract negotiations and potentially save millions of dollars each year through effective market/item analysis.

The VA defines item analysis as follows:

> Item price analysis is a process which analyzes and evaluates the price of pharmaceuticals, medical supplies, and non-perishable subsistence items that have the same salient characteristics with comparable level of quality serving the same end use. For pharmaceutical items, such items must meet regulatory standards (USP/NF) with associated bioequivalency.

This item analysis should compare unit prices by hospitals across the entire country for the same or comparable items during the same time period. Determining item comparability is important because there are a great variety of similar commercial items in the medical supply marketplace.

Because of the variations in products and prices, the VA needs a mechanism for collecting and analyzing current pricing information. This will enhance market analysis and provide the foundation for evaluating vendor bids for VA depot awards. Monitoring prices will also assist in making wiser FSS purchases and more knowledgable local procurements.

The VA needs to broaden the market analysis responsibilities of the Marketing Center and strengthen its capabilities to monitor and report current item prices. Coordination of market analysis requires management of a data base dedicated to price comparisons. At a minimum, the unit price of all depot supplied items should be analyzed at regular intervals.

In order to compare VA depot prices paid by organizations of comparable size and influence, the VA should conduct aggressive national price research and analysis. The VA should establish

and maintain a small staff of four to five price analysts in the Marketing Center dedicated to market analysis. This group should routinely collect and analyze supply market information from all available sources. This staff would maintain the data base for depot item price analysis, publish FSS "best buy" guidance to VA stations, and collect information on local purchase trends.

The VA should also designate a single senior supply officer in each VA region. Such officers should be responsible for monitoring market prices, collecting price information on a regular basis, and forwarding same to the Marketing Center for inclusion in the VA data base. Each of these officers should also be authorized to officially apply for membership in a major group purchasing organization in the region to effectively collect meaningful primary information.

Our research has not identified any regulatory or legal constraints associated with a VA medical center joining group purchasing organizations.

In addition, VAMCs should have the authority to procure through these group purchasing organizations when items are available at more economical prices. We have researched this latter issue from a regulatory and legal standpoint. We believe that such a recommendation is not in conflict with existing constraints if implemented in accordance with the FAR and as described below.

VAMCs, through the VA regional office, would join large group purchasing organizations. The VAMCs would not bind themselves to purchase minimum quantities of products or to expend a minimum amount of funds. The VAMCs would use the group purchasing organization's contracts in the same manner as government activities now use basic ordering agreements. VAMC contracting officers would only procure to fill a requirement for supplies, basically the same manner in which VAMCs now conduct local procurement.

In the above scenario, the VA (as a government activity) would not be delegating or transferring its procurement responsibilities or functions. It would purchase only when it required supplies. VA contract specialists and buyers would perform their normal functions, including exercising judgment as to whether the procurements were in the government's best interest. Generally, these procurements would be less than $10,000. Therefore, advance notifications in the Commerce Business Daily would seldom, if ever, be a factor.

A possible limiting factor is the applicability of specific statutory and regulatory socio-economic clauses. However, these clauses apply only to purchases of more than $2,500. Since many VAMC procurements would likely be below that threshold, the impact of such clauses may not be as severe.

Lastly, such procurements appear to be within regulatory funding provisions and not in conflict with the Anti-Deficiency Act (as provided in FAR 32.702).

Recommendations:

(1) **The VA should strengthen the market analysis capabilities of the Marketing Center and its ability to monitor and report on current item prices, by (a) establishing a staff of price analysts dedicated to supply market analysis; (b) designating senior supply officers in each VA region and making them responsible for monitoring market prices; and (c) authorizing these designated supply officers to officially apply for membership in a major group purchasing organization to collect primary pricing information.**

(2) **The VA should permit its medical centers to purchase through group purchasing organizations when item prices are more economical than any other source.**

D. LOWEST COST METHOD OF SUPPLY

INTRODUCTION

In this section, we discuss the major opportunities available to the VA to improve cost effectiveness and to realize the lowest cost method of supply. These systemwide improvements include instituting a national supply standardization program; modernizing supply automation; improving the management and control of the transportation function; and, other supply factors which, in our opinion, can improve cost effectiveness.

1. Standardization Within the VA

The purpose of standardization is to reduce the number of different types and brands of items that serve the same functional use. The ultimate goal of standardization is more cost-effective and efficient operations that, at the same time, deliver quality medical service. Standardization benefits patients, medical staff, the procurement and distribution processes, as well as manufacturers and vendors.

The private sector's experience with standardization has demonstrated that it can significantly reduce materials management costs without jeopardizing medical services. Hospitals are using their standardization committees -- consisting of physicians and nurses, material managers, and hospital administrators -- to effectively plan and implement standardization programs.

Several private sector hospital systems have developed standardization programs directed by corporate headquarters. Humana, Inc.'s program is one of the most successful in this regard. Real standardization is accomplished through corporate-wide policy, procedures, and goals. Humana hospital officials are required to justify deviations from a standard item through an exception process. Humana's corporate goals include standardizing 85 percent of all medical supplies and reducing overall item cost by 17 percent. During the last 3 years, Humana has saved $57 million through standardization. In 12 general commodity areas, Humana has reduced costs by at least 20 percent.

The Sisters of Mercy Health Care Corporation (SMHC) has also made systemwide gains in standardization. Through its central procurement activity for national level contracts, SMHC has standardized more than 3,000 pharmaceutical and 500 medical supply items. At least 75 percent of its hospitals have accepted standardization of these items, with an overall item price savings of 23 percent.

Currently, little emphasis is placed on standardization in the VA, and a systemwide standardization program does not exist. There is no single governing body at the VA Central Office (VACO) involved in such a program, and no policy or planned initiatives for implementing such a national program. The administration at each VAMC functions autonomously as to types and brands of items used. In general, there is considerable reluctance to stop using certain items, even if lower cost substitutes exist in the depot. Thus, if the exact item desired by the VAMC is not stocked by the depot, procurement is usually authorized from other sources -- normally at higher costs. There is no attempt in the VA to mandate use of a "medically equivalent" substitute from the depot, at lower costs.

The VA practice of professional/personal brand preference procurement is costly. In FY 85, 75 percent of all VAMC expenditures were not centrally procured. Over 68 percent ($589 million) of all VAMC expenditures for medical supplies and pharmaceuticals were from either FSS or local procurement.

Clearly, a major standardization program, with systemwide commitment by the VACO, all VAMCs, the Marketing Center, and depots, is vital to the VA. Such a program, fully implemented, mandated, and pursued, could save the VA millions of dollars annually.

To determine the potential savings from such a program, Coopers & Lybrand conducted an item analysis of more than 100 medical supply and pharmaceutical items. In all cases, C&L was careful to ensure the credibility of medically equivalent items. Of more than 100 items sampled, there were satisfactory

test comparisons (medical equivalence) for 89 items. The results showed that for 46 medical supply items, potential savings through standardization for 1 year were $894,856; for 43 pharmaceutical items, potential savings were over $2.7 million. The combined 1-year potential savings for the 89 items was $3.6 million.

In order to be successful, a standardization program in the VA must be centrally supervised and managed by the Central Office (VACO). It would require a multidisciplinary approach, involving participants from various VA medical and materials management staffs. The program must be based on a structured plan, with well-defined VACO policy, procedures, and both organizational and individual performance goals (stated in dollar savings).

The VA depot wholesale distribution system represents the greatest opportunity to initiate a standardization program and realize acquisition savings. More than 1,300 medical supply and pharmaceutical items are already stocked in the depots. These items are already satisfying the functional requirements of many VAMCs, at costs lower than other sources.

The procurement structure already exists to support a standardization program. The Marketing Center now functions very well as the VA's central procurement activity. As such, the Marketing Center constitutes a logical focal point from which to devise and implement a standardization program, and should play a primary role in market analysis, data collection, VA performance measurement, and decision making.

Recommendation: **The VA should plan, implement, and supervise, a national program to standardize the medical supplies and pharmaceutical items used in VAMCs. Such a program should be centrally supervised and managed by the Central Office, involve VA medical and materials management staffs, and be based on a structured plan, with well-defined VACO policy, procedures and goals.**

2. Modernizing Supply Automation

Data processing support for most VA supply functions is provided by the LOG I system, installed nearly 20 years ago. Since its installation, the LOG I system has been continuously expanded and enhanced to meet new requirements.

LOG I enhancements have not corrected design deficiencies, but rather have taken advantage of developments in data processing. LOG I was designed and operates as a second generation system; current technology is fourth generation. The challenge, then, is to incorporate current data processing technology into a contemporary architecture, while avoiding a lengthy and costly redesign process. LOG I must continue to provide ongoing support and immediate benefits during the transition.

While a review of automated systems was not a formal component of this contract, we documented deficiencies, limitations, and opportunities for enhancement in the existing systems. We met with several user personnel plus others responsible for system design and development. This provided us with an understanding of the automation requirements necessary to support VA supply service operations.

The LOG I system provides automated supply support in four areas: catalog maintenance; equipment inventory; depot support; and field station inventory. Our proposed automation enhancements address each of these basic and interrelated LOG I functions.

Cataloging

The catalog function provides a unique item identification (National Stock Number) for approximately 40,000 items. For each item, storage and shipping characteristics are maintained. Cataloging transactions perform file maintenance and link with other government cataloging systems to coordinate stock number assignment and responsibility for item maintenance.

We propose enhancements to the cataloging function, such as expanding systemwide oversight of supply purchases (including item quantities and prices through FSS and local procurements), and expanding the catalog record to permit additional item attributes.

Equipment Inventory

The LOG I system provides support for the VA inventory of nonexpendable equipment, maintained in the Consolidated Memorandum Receipt file. System integrity is a primary objective and is achieved through an annual inventory verification. Existing reports provide consolidated information used by the VA Central Office to project equipment expenditures and maintain intra-agency control.

This equipment inventory function appears to operate adequately in the current batch mode. The current weekly update is sufficient and we see no reason for major restructuring. Instantaneous identification of equipment location and characteristics through an on-line data base management system appears excessive. Consequently, the cost of a major effort to restructure this function is not justified.

Depot Support

The LOG I system supports depot procurement, storage, and distribution, and generates a number of special reports for monitoring supply performance. Special requests over the past 17 years have caused the depot support function to evolve into a large, complex processing system. The primary enhancements (not basic design changes) to this function are to improve timeliness of data entry and reporting, facilitate special reporting, eliminate manual processing, and establish linkages with other systems.

Current delays in status reporting inhibit control of vendor performance. Periodic studies have shown that only 60 percent of vendor deliveries are within 2 weeks of the due date. This

creates the need to maintain excessive safety stock supply levels. Managing inbound transportation requires more timely reporting than currently available.

Depot storage capacity could be improved considerably by using a cubic stock locator system. Currently, Hines depot receipts are manually reentered into a separate random locator system for placement. This considers only the area required, not the cubic displacement. Thus, warehouse usage is considerably below that in the private sector.

Facility Supply Support

The LOG I system supports field stations in ordering, storing, and issuing supplies. Automated preparation of issue books simplifies ordering routine supplies. Requirements analysis is the basis for station supply management. This report presents stock status, demand history, computed order parameters, and summarizes item usage.

Orders are automatically generated for depot and GSA items based on the requirements analysis. This system prepares an order for release or modification. Simarily, depot receipts may be accepted with a single transaction.

These features of the station supply system provide true management by exception. As with the depot support function, primary enhancements are proposed to improve timeliness and eliminate duplicate manual processing. (Most field stations maintain manual logs to record receipts because of the delay in receiving automated confirmations.) Also, on-line inquiry would make access to an expanded catalog realistic, provide lowest available prices, and permit nondepot orders to be monitored. This would provide the automated oversight of purchases necessary to achieve major savings in supply management.

We propose that the VA consider three implementation alternatives -- system acquisition, phased development, and total redesign -- that represent varying resource investments.

- The system acquisition alternative would minimize elapsed time and system development costs, but may require extensive retraining of VA supply staff to work with a different system. Many of the design changes that were specifically included in LOG I would be lost.

- With phased development, the majority of program modules are "device independent," so only the executive routines need be replaced to operate in an on-line environment. This, as with all approaches, would require considerable new equipment acquisition. The system could continue operating in batch mode until the on-line conversion.

Subsequent phases would involve conversion to a data base structure, linkages with other systems, and expanded oversight to include all purchases. This approach would require the maximum elapsed time greater systems development costs because of concurrent activities and minimal training costs due to familiarity with the system it would provide immediate benefits to systems users and demonstrate progress. Funding can be managed over a longer time period and parallel operations would always be available as a fall-back to sustain operations.

- A total redesign, including proposed enhancements, could be achieved in less time and at slightly less cost than the phased development. Training time would probably be comparable to the system acquisition approach. The project would be vulnerable to funding reductions.

Recommendations: (1) The VA should proceed with the conversion of LOG I from a batch processing system to an on-line environment.

(2) The VA should convert the LOG I system from a transaction oriented processor to a data base structure.

(3) The VA should expand the linkages and communications among automated systems.

(4) The VA should incorporate the phased development alternative.

3. Improving the Transportation Function

Transportation is a major cost in a supply system. Traffic management is about one-third of the production costs of most commodities. Of total distribution costs (transportation, warehousing, materials handling, and inventory control), transportation accounts for about half.

Many changes have occurred in the transportation industry and traffic management in recent years. These include new rate setting concepts, the application of data processing techniques, the push toward lower inventory levels, and new transportation services (contract carriers).

Traffic management in the VA supply system extends only to outbound shipments, from the depots to the medical facilities or other VA customers. During FY 85, the VA expended more than $3.2 million to move customer goods.

Each depot has its own transportation section which handles all outbound shipments for its region. Depot traffic managers must decide a variety of questions, including what mode (truck, train, mail) of transportation and what kind of equipment is needed to move the goods; if load is less-than-truckload (weight less than 40,000 pounds), whether a stop-off should be used (in which a partial load to a customer is combined with another customer's shipment). In FY 84, there were more than 43,500 shipments to customers requiring these kinds of transportation decisions.

The VA's approach to inbound transportation is a traditional one: transportation costs are built into the depot item purchase price. This approach is based on the Marketing Center's determination that FOB destination (in which the cost of shipping and

risk are borne by the seller) is the most advantageous delivery method for depot-stocked items.

Because the VA uses FOB destination for delivery of all depot items, it does not examine the total transportation cost of goods moving through the VA's multistaged distribution system (vendor, depot, customer). We believe that the VA could realize significant cost savings by improving control over total transportation cost.

Private sector firms have taken this total control approach. For example, Xerox is reducing transportation costs by relying more heavily on freight consolidation. 3M has created a separate unit to reduce inbound freight costs. Humana, Inc., negotiates its national contracts with the cost of transporting the specific product to a given destination as a separate and distinct cost. This inbound transportation charge is reviewed to determine its cost effectiveness. If the cost is less than competitive, Humana will negotiate a separate contract for transportation.

We believe that the VA needs a transportation manager well versed in transportation law, government regulations, traffic routing techniques, transportation software, and related areas. Such a position is well justified when considering total VA transportation costs, estimated at $7.8 million (inbound $4.5 million, outbound $3.3 million) compared to total depot operating costs of $9.9 million.

Organizationally, the position should be located in the VA Central Office, with responsibilities more managerial in nature than operational. The transportation manager would be responsible primarily for (1) determining VA responses to transportation environments, and (2) interacting with other VA distribution managers.

The VA has the opportunity to use substantially reduced freight rates to move its depot-supplied items. This is in lieu of vendors' "best possible delivery method" which is less-than-truckload shipments. Potential first-year savings could exceed

$1.3 million if the current small shipments were consolidated into truckload shipments.

Recommendations:

(1) The VA should centralize its control of the transportation function.

(2) The VA should reinstate the position of Manager of Transportation.

(3) The VA should manage the inbound transportation function of its depot system.

(4) The VA should use "voluntary competitive bid tenders" in selected traffic areas in its management of the outbound transportation function of the depot system.

4. OGA Markups

The primary mission of the VA depot distribution system is to "receive, store and issue medical supplies, equipment and non-perishable subsistence" to VA medical centers and all other VA-operated facilities. In addition to meeting these internal supply needs, the VA depot distribution system also ships supplies to more than 1,400 other government agencies (OGAs). All customers -- whether OGA customer or VAMC -- pay a single price (catalog price) for each supply item.

In FY 85, total VA depot shipments to OGAs amounted to $22.1 million. This represents approximately 7.7 percent of total VA depot sales. While it is convenient for OGAs to order their supplies from the VA depots, this service is basically disruptive to the VA system. OGAs order on an irregular basis, and, generally, in small quantities, resulting in a much higher material handling cost than the processing of supply orders from VAMCs.

The ratio of transportation costs to sales is three times higher for OGAs than for VAMCs. In FY 85, actual transportation expenses for OGA shipments were approximately $630,000. This represents approximately 2.85 percent of the total value of OGA sales. Transportation expenses for VAMC shipments during the

same period were approximately $2.65 million. This represents approximately 1.0 percent of VAMC sales.

Other major federal supply agencies such as the Defense Logistics Agency (DLA) add processing surcharges to orders from OGAs. Typically, this surcharge is 3.5 percent.

If the VA were to institute a markup on supply sales to OGA customers, the revenues would be credited directly to the Supply Fund. Based on FY 85 sales to OGAs of $22.1 million, the VA would realize annual revenues of between $442,000 (2% markup) and $1.1 million (5% markup). If the VA employed the same 3.5 percent markup as DLA, annual revenues would be $773,500. These incremental revenues could be used to offset the higher material handling costs and greater transportation expenses for VA processing of OGA shipments. If the VA is to continue providing services to OGAs, then those organizations should be willing to share in the cost of providing such services.

Recommendation: **The VA should institute an order processing surcharge of 3.5 percent of the value of all supplies purchased by OGAs.**

5. Utilization of Storage Space

The VA currently measures the usage of depot storage space in terms of floor space utilization. The utilization ratio reported is a rough approximation of the percentage of storage slots (pallet slots or bins) that are occupied by supplies.

This is not the most accurate method for measuring space utilization for two reasons. First, a storage slot is considered occupied (utilized) if a pallet containing supplies is located in the slot. This measurement does not differentiate between pallets containing 1 case or 100 cases. Second, the measurement fails to consider vertical storage. As long as supplies are located on the top shelf of a multishelf storage rack, the space is considered utilized. However, there may be considerable vertical distance between the ceiling and the supplies stored on the highest shelf.

Many private sector organizations now measure both storage capacity and utilization in terms of cubic space. This provides a more accurate measurement of storage capacity.

A long-term benefit of cubic storage space utilization is that the VA would maximize the total vertical and usable storage space available at each depot. The VA would also be able to more accurately forecast its transportation requirements.

It would appear that the LOG I system would also require modification if the VA were to use it to measure cubic storage utilization. The picking document could be modified to display the consolidated weight and cubic displacement for each order. The shipping department could accurately forecast transportation requirements before orders were even picked. This would allow the VA to minimize transportation costs, and reduce the total elapsed time between order picking and shipment.

The major cost of increasing storage capacity would be for shelving and equipment needed to utilize vertical storage space. In our analysis of the alternative to consolidate depot facilities, we estimated this cost to be $12.25 per square foot of usable storage space. The total estimated cost for the shelving and equipment was more than $12 million.

Recommendation: **The VA should establish a policy of measuring storage capacity in terms of cubic measurements.**

6. Delivery Schedule

The VA depot distribution system generally provides scheduled deliveries to the VAMC stations once a month. Our analysis of break bulk distribution systems demonstrated that increased vendor lead-times would increase VA safety stock requirements and correspondingly increase average inventory levels. If the monthly delivery schedules were increased in frequency, the corresponding lead-time between VAMCs and depots would be reduced. More frequent deliveries to the VAMCs would result in reduced safety stocks and average inventories. It would also reduce VAMC dependency on local procurement.

We do not anticipate any significant change in VA depot inventory levels with more frequency deliveries. Depot inventory levels are primarily influenced by replenishment order frequency quantities (assuming that depot inventory levels remain relatively stable).

The most significant offset to savings from VAMC reduced inventories would be increases in transportation expenses between the depots and the stations. More frequent shipments would likely require use of more expensive, less-than-truckload freight rates. The VAMCs would also realize increased labor costs for receiving and stocking supplies. Additional labor would also be required at the depots for processing more frequent shipments.

It was not possible to pinpoint the exact cost of transportation between the depots and the stations for more frequent deliveries. The VA uses truckload quantity shipments. There are no published government tender rates for less-than-truckload (LTL) shipments, which are considerably higher and vary between states.

We estimate that transportation costs for shipments from the depots to the VAMCs would increase dramatically as frequency of delivery increased. This is primarily due to the shift from economical truckload freight rates to the more expensive less-than-truckload rates. These higher rates, coupled with the greater absolute number of shipping transactions result in a total cost of transportation which is nearly 50 percent higher than current costs.

It is also difficult to precisely determine the incremental labor required at either the depots or stations to accommodate the increased frequency of deliveries. We estimated that the staffing in the depot shipping areas would double in size if the frequency of delivery increased from once to twice a month. Total annual cost of salaries and fringes for incremental labor at the depots would be approximately $500,000 per year (with deliveries to VAMCs every 2 weeks).

If deliveries to the VAMCs were doubled from once a month to once every 2 weeks, we estimated that the incremental labor required at each VAMC would be equivalent to approximately .2 FTE. Annual cost of salary and fringes for the incremental labor would be approximately $775,000 per year.

In order to determine whether more frequent depot deliveries to the stations would be cost effective, we compared potential savings from reduced VAMC inventories to any resulting incremental expenses. We estimated that VAMC inventories would be reduced by more than 80 percent if deliveries were increased to once a week.

We concluded that it would not be cost effective for the VA to increase the frequency of deliveries between the depots and the VAMCs at this time. Expenses would clearly increase at a greater rate than any potential savings realized from reduction of VAMC inventories. The shift from truckload rates to LTL rates and the greater absolute number of shipment transactions would result in substantial increases in total cost of transportation. In addition, the calculated time value of inventory for the VA now is substantially lower than the inventory holding costs typically experienced in the private sector.

Finding: **The current once-a-month shipments from depots to VAMCs is cost effective and should not be changed.**

7. Inspection Function

The service and reclamation function at the depots provides centralized quality assurance and acceptance testing for all supplies maintained within the depot system. Samples of each major commodity group shipped to the depots are tested to make sure these products meet the procurement specifications.

The service and reclamation function has several other major responsibilities. It provides repair services for major medical and x-ray equipment located within the VAMCs and conducts the silver recovery program.

The VA acceptance testing process is beneficial for those product groups in which there is considerable variation in major characteristics of the finished products. Such variation occurs most commonly with non-perishable subsistence. Quality levels are more consistent for medical/surgical and pharmaceutical items.

Two key product groups which require continuing inspection are non-perishable subsistence and products obtained from the National Institute for the Blind, the National Institute for the Severely Handicapped, and the Federal Prison Industries. Nearly all products obtained from these sources are produced in highly labor intensive environments; inspection insures that product specifications are met.

Finding: **The inspection function for all supplies appears to be cost effective and should be continued.**

8. Inventory Levels

The VA depot distribution system supports the supply requirements of the VAMCs at a very efficient cost and consistent level of service. During our analysis of the depot distribution system baseline cost, we identified the major expenses associated with this system, including the investment required for inventory at the depot level.

The VA maintains a substantial inventory investment at the depots. Our review of private sector multihospital systems revealed no centralized supply distribution systems comparable to that of the VA. The only health care supply distribution systems with any similarity were medical supply distributors such as American Hospital Supply Corporation (AHS). In a somewhat similar fashion, both the VA and AHS receive and store supplies from large numbers of vendors and manufacturers, and reship the supplies to large numbers of end-users.

Differences in business orientation (mission) preclude any practical operational comparisons between the two distribution

systems. Yet, one observation regarding inventory is applicable. Private sector supply distribution companies typically operate with an inventory investment representing approximately 45 days inventory on hand. However, there are a number of factors that influence the inventory levels maintained within the VA depot system.

The VA depots maintain substantial levels of safety stock because of the variation between vendor projected lead-times and actual delivery time. Longer lead-times and inconsistent vendor deliveries have a dramatic effect on safety stock levels.

The VA depot distribution system maintains a very high service level to the VA end-users; approximately 98 percent of all supplies ordered by the VAMCs are shipped by the depots without any back orders. The VA depot distribution system also services a large number of OGAs. These customers order on an irregular basis. The relatively unpredictable OGA demand makes it necessary for the VA depots to carry higher levels of inventory.

There are a number of factors which contribute to the current levels of inventory investment at the VA depots. If we measure the value of inventory reduction in terms of time and value of inventory (8.17%), savings available to the VA can be substantial. Reducing the amount of on-hand inventory also makes additional storage space available. This gives the VA flexibility to bring additional items into depot inventories and realize the associated savings with lower unit supply costs and standardization.

We recommend that the VA establish goals to reduce depot inventories on an annual basis. These goals should be set in terms of days of inventory on hand. However, the VA must achieve improved lead-time performance from vendors and improved capabilities from the LOG I system before attempting to implement this recommendation.

Recommendation: **The VA should establish goals, in terms of days of inventory on hand, to reduce depot inventories on an annual basis.**

9. Commodity Mix

The VA depot system procures, stores, and ships supply items from three major commodity groups: medical/surgical supplies, pharmaceuticals, and non-perishable subsistence. Annual shipments in FY 85 were $78 million for medical/surgical, $175 million for pharmaceutical, and $32.5 million for non-perishable subsistence.

Pharmaceuticals represent a relatively high cost per unit and a low to-unit-weight/cubic displacement. In contrast, non-perishable subsistence items typically have low unit cost and high to-unit-weight/cubic displacement. As a result, non-perishable subsistence requires a disproportionate amount of storage space in relation to inventory value, especially when compared to the storage space required versus inventory value for pharmaceuticals.

Although non-perishable subsistence represents a small percentage of total VA depot shipments (11.4%), there is a benefit to maintaining this commodity in the depots. The relatively large cubic displacement of the commodity assists the VA to ship most orders in truckload quantities to the VAMCs. Freight rates for truckload shipments are considerably less expensive than the rates for less-than-truckload quantity shipments. Thus, the VA has been able to keep freight expenses quite low relative to the total value of shipments.

It has been demonstrated several times during this project that the VA has done an excellent job managing those products maintained in the depot system. The item analysis in Phase II, and the analysis of the direct vendor delivery alternative demonstrated that the VA achieves the lowest unit pricing for depot supply items. The criteria used to qualify supply items for depot stock is one of the major reasons we believe standardization can be successful in the VA. Finally, the depots

have been able to offer high levels of customer service to the VAMCs with consistent, reliable delivery.

It appears beneficial for the VA to increase the pharmaceutical and medical/surgical products currently managed within the depot system. These represent the greatest opportunities to reduce current nondepot purchases by the VAMCs.

Recommendation: **The VA should increase the number of supply items managed within the VA depot distribution. (Priority should be given to items from the pharmaceutical and medical/surgical commodity groups.)**

10. Inventory Stock Criteria

The VA depot system currently maintains approximately 1,650 different supply items. These items represent medical/surgical, pharmaceutical, and non-perishable subsistence commodities.

In order for a supply item to be stocked in the VA depot system, it must have minimum annual sales of $25,000, be used by at least 25 VAMCs, and be priced at least 15 percent less than the next lowest priced source.

A criterion requiring at least 25 end-users encourages standardization. The depot distribution system represents an excellent vehicle for increasing levels of standardization within the VA supply system.

The survey conducted as part of our analysis of direct vendor delivery demonstrated that supply costs would be an average 26.6 percent higher without the current depot system of distribution. While this was not representative of every item stocked, it was a strong indicator of the savings currently realized through the depot distribution system.

There is no widely accepted criteria in the private sector used to determine which supply items should be added to the inventory. A common practice in private sector hospitals is to require that items be commonly used by more than one end-user

department. There is no common dollar threshold requirement used within private sector hospitals. Likewise, there is considerable variation as to the absolute number of supply items maintained within the inventory period.

Supply distribution companies use somewhat different criteria when determining particular items to carry within their inventories. These companies must balance projected transportation expenses and inventory carrying costs against the expected item profit.

It would not be economically feasible for the depot system to stock every supply item used by the VAMCs. Space limitations are the final constraint to adding new items to depot inventories. However, until these space limitations are reached, the VA can potentially achieve additional savings in the total cost of supplies by adding more supply items to the depot system.

A survey conducted during the direct vendor delivery analysis clearly demonstrated the VA's capability for achieving favorable unit pricing for those items maintained within the depots. An even greater number of items may qualify for depot stocking if the basic depot criteria were adjusted.

We believe that the VA should lower the unit price savings criteria for adding new items to depot inventories. This should be done on a progressive basis, with available storage space being the primary constraint. As long as the savings in unit supply costs exceed the time value of required inventories, it would be beneficial for the VA to carry an item in the depot inventory. Even if the unit price savings averaged only 10 percent, the VA could still potentially save millions of dollars.

Recommendation: **The VA should consider lowering the unit price savings criteria for adding new items to the depot inventories.**

III. LIST OF FINDINGS AND RECOMMENDATIONS

INTRODUCTION

This section contains a list of all findings and recommendations discussed in Section II of the report.

A. COST-EFFECTIVE ALTERNATIVES TO THE VA DISTRIBUTION SYSTEM

1. National Contracts for Direct Vendor Delivery

   - The VA should not replace the depot distribution system with an alternative system providing for direct vendor delivery.

2. Defense Logistics Agency (DLA) Assumption of VA Wholesale Depot Operations

   - DLA assumption of the procurement and distribution functions for the VA is not a cost-effective alternative at this time.

3. Additional Depot Facilities

   - The VA should not add a depot to its present distribution system.

4. Consolidation of Existing Facilities

   - Although potential system savings exist through consolidation (whether reduction to two or one), no alternative is operationally feasible with current facilities. The current three depot system should remain.

5. Conversion of Depots to Break Bulk Facilities

   - Under certain conditions, it would appear the break bulk scenario might result in some net savings for the VA. However, projected increases in VAMC station inventories would be nearly the same or greater than the inventory reductions realized at the VA depot level. Consequently, it does not appear practical to implement such a system.

B. ALTERNATIVES AND RECOMMENDATIONS PERTAINING TO THE VA PROCUREMENT PROCESSES

ALTERNATIVES TO MARKETING CENTER PROCUREMENT PROCESSES

1. Multiyear Contracting

   - The VA Marketing Center should employ multiyear contracting on a selected basis. The length of these contracts (whether 2 or more years) should be left to VAMC management discretion, based on their expertise, current negotiations, and the Marketing Center's prior experience in purchasing respective items.

2. National Contracts Program for Nonstocked Pharmaceuticals

   - The VA should expand the number of pharmaceutical items procured through the National Contracts Program for nondepot stocked items. Current VA experience indicates that under such an expanded program, millions of dollars in potential savings are probable.

3. Federal Supply Schedule Contracts

   - The Marketing Center should identify a candidate number of FSC 6510 non-critical items and convert these from FSS multiple-award to single-award schedules.

   - The VA Marketing Center should reduce its dependence on multiple-award schedules for pharmaceuticals and increase its use of the National Contracts Program for this commodity.

4. The VA/DOD Shared Procurement Program

   - The VA and DLA should continue to expand their efforts to identify new medical supply and pharmaceutical items to bring into the program, particularly items that are now bought primarily from local procurement sources, since these items are normally associated with the highest prices.

ALTERNATIVES TO VA MEDICAL CENTER PROCUREMENT AND CONTRACTING PROCESSES

1. Local Procurement

   - Each VAMC should solicit and award annual indefinite quantity requirements contracts with local vendors/ distributors.

- Where two or more VAMCs are located in the same city or in close proximity, they should consolidate requirements and purchase as a buying group, using indefinite quantity requirement contracts.

2. Federal Supply Schedule (FSS) Purchases

- The VAMCs should reduce their dependence on FSS by employing preaward indefinite quantity requirement contracts in each VAMC local area and by increasing their use of the National Contracts Program.

3. Amendment of VAAR 808.001

- Amend VAAR 808.001 as discussed.

4. Purchasing Responsibilities Within the VA Medical Centers

- All purchasing responsibilities within VAMCs should be centralized in the supply services organization.

C. SYSTEMWIDE MARKET ANALYSIS

- The VA should strengthen the market analysis capabilities of the Marketing Center and its ability to monitor and report on current item prices, by (1) establishing a staff of price analysts dedicated to supply market analysis; (2) designating senior supply officers in each VA region and making them responsible for monitoring market prices; and (3) authorizing these designated supply officers to officially apply for membership in a major group purchasing organization to collect primary pricing information.

- The VA should permit its medical centers to purchase through group purchasing organizations when item prices are more economical than any other source.

D. LOWEST COST METHOD OF SUPPLY

1. Standardization Within the VA

- The VA should plan, implement, and supervise, a national program to standardize the medical supplies and pharmaceutical items used in VAMCs. Such a program should be centrally supervised and managed by the Central Office, involve VA medical and materials management staffs, and be based on a structured plan, with well-defined VACO policy, procedures, and goals.

2. Modernizing Supply Automation

   - The VA should proceed with the conversion of LOG I from a batch processing system to an on-line environment.
   - The VA should convert the LOG I system from a transaction-oriented processor to a data base structure.
   - The VA should expand the linkages and communications among automated systems.
   - The VA should incorporate the phased development alternative.

3. Improving the Transportation Function

   - The VA should centralize its control of the transportation function.
   - The VA should reinstate the position of Manager of Transportation.
   - The VA should manage the inbound transportation function of its depot system.
   - The VA should use "voluntary competitive bid tenders" in selected traffic areas in its management of the outbound transportation function of the depot system.

4. OGA Markups

   - The VA should institute an order processing surcharge of 3.5 percent of the value of all supplies purchased by OGAs.

5. Utilization of Storage Space

   - The VA should establish a policy of measuring storage capacity in terms of cubic measurements.

6. Delivery Schedule

   - The current once-a-month shipments from depots to VAMCs is cost effective and should not be changed.

7. Inspection Function

   - The inspection function for all supplies appears to be cost effective and should be continued.

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